

Duties and Responsibilities of RICU Medical Personnel

The RICU is staffed by two PGY II's, one pulmonary/critical care fellow, and one attending physician. Emergency Medicine residents and fourth year medical students will also rotate through the unit from time to time.

The residents have the primary responsibility for the care of all patients in the RICU. They should write all orders (except DNR). Fellows and attending physicians will not ordinarily write orders (except in urgent situations). When called upon to correct or clarify any housestaff orders, the attending physician or fellow should bring the issue to the attention of the house officer. The attending physician has the responsibility to issue DNR and DNI orders.

Progress notes are written daily by the residents. If a fourth year medical student writes a progress note, the resident is responsible to review and countersign the student note **AS WELL AS DOCUMENT HIS OWN PHYSICAL FINDINGS AND ASSESSMENT**. Admitting Physician Assessment form must be completed by a resident physician.

ALL ENTRIES IN THE MEDICAL RECORD MUST BE DATED AND TIMED. This includes progress notes, consultations, and procedure notes.

The RICU has a capacity of eight patients. Therefore, each resident will generally have primary responsibility for four patients. Cross coverage responsibility is for up to eight patients. The number of new RICU admissions per 24 hour period very rarely exceeds 3. The number of daily RICU consultations is usually up to 3.

The RICU fellow (or the resident on call when the fellow is not immediately available) is responsible for performing RICU acceptance evaluations on the wards and in the Emergency Department. All patients newly admitted to the hospital must have the white Physician Assessment (h&p) form and DVT risk assessment screen filled out. Residents will review all such pulmonary/critical care consultations with the covering fellow, who will further consult the attending RICU physician. Appropriate documentation of this process will be made by the attending physician in the patient record. If the patient is not transferred to the RICU, the RICU or pulmonary consult fellow and attending will provide the ongoing follow-up consultations. At night and on weekends the RICU resident on call may be called upon to perform urgent pulmonary consultations on other services. The resident will then review each case with the fellow on call. The RICU attending physician on call will supervise these consultations as well. Pulmonary/critical care consultations performed during nights and weekends requiring ongoing consultation should be brought to the attention of the pulmonary consult fellow and attending physician during the next morning for appropriate follow-up (except for patients already being managed in the RICU). Fellows will maintain a log of critical care consultations as well as the other procedures performed in the RICU. The consultation log book and procedure log book are maintained in the RICU and are to be updated daily. There will be a low threshold for the fellow and RICU attending to return to the hospital for direct intervention. Prior to leaving the hospital for the day, the RICU fellow should make walk around rounds with the on-call resident to discuss ongoing and potential management and triage issues. The RICU resident and fellow on call will communicate each evening at approximately 8 PM and as needed to again discuss ongoing and potential management and triage issues. **The on call resident is not permitted to participate in patient care after 10 AM the next morning;** after updating the RICU team he should leave the building.

The fellow is **required** to return to the RICU for the following indications:

1. PA catheter insertion
2. Emergency bronchoscopy
3. Patients returning from surgery (including post tracheostomy)
4. Unstable patients –e.g.,
 - a. Patients newly in shock
 - b. Patients who significantly deteriorated since the fellow left
 - c. Patients who can no longer be adequately ventilated
 - d. Patients with myocardial infarction or cerebrovascular accident
5. Intubated asthmatics with a respiratory acidosis, elevated peak airway pressures, or other ventilatory difficulty
6. Patients who require physical examination or review of radiographic studies by a senior physician
7. To medically clear a patient in the RICU who needs to go to surgery.
The RICU fellow must personally examine the patient and communicate with the RICU attending
8. To perform a “terminal wean”
9. Any other patient deemed to be too difficult for the resident to manage alone
10. If therapeutic decisions or procedures are deemed to be difficult or controversial the RICU fellow must contact the RICU attending promptly

Fellows serve as supervisors and teachers of the residents. Fellows conduct daily work rounds with the residents, examine patients, plan management strategies, collect and review laboratory data and discuss relevant topics. Attending rounds are then conducted each day at 8:30 AM (8 AM on Wednesdays, weekends, and holidays). At this time, Daily Goals (patient status, plans of action, and laboratory results, and triage decisions) are updated and reviewed along with current radiographs. During these sessions, one or two relevant topics will be discussed in depth with the attending. Items on the Daily Checklist are addressed for each patient. Interdisciplinary rounds are held regularly each Monday and Thursday at 1PM following noon conference.

In addition to the teaching forums directly associated with the RICU, residents are encouraged to attend the other didactic conferences held by the pulmonary division throughout the week. Each Thursday (except the 2nd of the month) at noon a critical care conference is held in the RICU conference room in which a recent case is presented to the RICU attending staff for lively interactive discussion of relevant concepts in pulmonary/critical care management. On the 2nd Thursday of the month a journal club is held and each of the two fellows presents a recent article for critique. On the first Tuesday noon of each month on a rotating schedule the RICU, CCU or STICU attending presents a critical care didactic conference.

The resident will gain experience in invasive diagnostic and monitoring techniques utilized in the management of serious disorders of the respiratory and other organ systems. Additional exposure to complex therapies affecting the physiology of multiple organ systems, and legal/ethical questions regularly occurs. Each resident is given a copy of the RICU Syllabus. This evolving document discusses many basic topics that are important during the rotation. Respiratory topics such as airway management, ventilator management and weaning, barotrauma, chest tube management, treatment of asthma, COPD, ARDS, and pneumonia, and pulmonary physiology are discussed. Critical care topics frequently encountered such as severe sepsis, nutrition, dysfunction of other organ systems, monitoring, and ethics are also discussed. Important references are provided. The resident benefits

from direct patient care experience, didactic sessions, and using the syllabus as an introduction to in depth reading of the literature. **RICU admission and discharge criteria are also included.**

Residents are expected to learn the indications, risks, benefits, and as indicated, may learn how to safely perform a number of procedures. These may include insertion and management of central venous lines, arterial lines, and Swan-Ganz catheters, thoracostomy, thoracentesis, ventilator management, tracheostomy, and bronchoscopy.

The attending physician examines all new admissions, he reviews and signs the white Physician Assessment form, and he performs appropriate follow-up evaluations during rounds. The attending physician is responsible to review and countersign the DVT risk assessment screen and insure that appropriate DVT prophylaxis has been ordered. An attending physician is always available to help the residents evaluate clinical situations. The attending physician and fellow are available to supervise procedures that the residents perform.

At the beginning of the rotation expectations are discussed with the resident staff. At the end of the rotation each resident is formally evaluated (either by written or oral examination) by the attending physician, in order to judge how well the resident met the goals of the rotation. The resident will receive feedback about his performance throughout the rotation. In addition, the resident will have an opportunity to formally evaluate the rotation and make constructive criticism.

The resident will be evaluated in terms of:

Patient Care: Ability to accurately collect historical data, perform physical assessments, interpret laboratory data, formulate an assessment, and implement a plan of action.

Medical Knowledge: Depth relative to the level of experience, ability to acquire new knowledge, and ability to apply knowledge to patient care.

Practice-Based Learning Improvement: Ability to learn from experience and improve clinical skills.

Interpersonal and Communication Skills: Ability to communicate and establish a professional relationship with patients and families.

Professionalism: Ability to communicate with consultants, teachers, and other caregivers: demonstrate integrity and respect.

System-Based Practice: Ability to work within the healthcare environment and accomplish needed tasks.